STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF LICENSING AND REGULATORY SERVICES
-

Medical Use of Marijuana Program

Designation Form

(For patients to designate a caregiver or dispensary)

SECTION 1: Patient Information			
Legal Name:			
Date of Birth:	Driver's License No.:	Telephone No.: ( )	
Home Address:			
City:	State:	Zip:	County:
Expiration date of Physician Certification:			

SECTION 2: Cultivation Authorization

_____ # of flowering plants I will grow

_____# of flowering plants my caregiver will grow

_____# of flowering plants my dispensary will grow

Total # (Not to exceed 6) _____

SECTION 3: Marijuana Transportation

How will the medical marijuana be transported? (Check all that apply)

☐ I will pick up the marijuana from my designated caregiver/dispensary.

☐ The designated caregiver/dispensary will deliver my marijuana to me.

☐ Name of designated caregiver. (See Caregiver information section 4)

For questions regarding this program and/or application, please contact the following:

Department of Health and Human Services
Licensing and Regulatory Services
Maine Medical Use of Marijuana Program
41 Anthony Ave
11 State House Station
Augusta, ME 04333-0011

Tel: (207) 287-4325 Fax: (207) 287-2671 Toll Free: 1-800-791-4080 TTY users call Maine relay 711
Email: medmarijuana.dhhs@maine.gov

Office Use Only:
Check# _____ MO # _____ Amount $_____ Initials: _____ License# _____

SECTION 4: Caregiver Designation (Complete only if designating a Caregiver)			
Legal Name:			
Telephone No.: ( )			
Street Address:			
City:	State:	Zip:	County:
Caregiver MMMP Registration # assigned to this patient: (if cultivating for the patient and registration is required)			

Primary caregiver registration required; EXCEPTIONS, Section 5.4

- Section 5.4.1: A primary caregiver designated to cultivate for a qualifying patient if that qualifying patient Is a member of the household of that primary caregiver;
- Section 5.4.2: Two primary caregivers who are also both qualifying patients, if those primary caregivers are members of the same household and assist one another with cultivation;
- Section 5.4.3: A primary caregiver who cultivates for a qualifying patient if that qualifying patient is a member of the family of that primary caregiver (see 22MRSA 2423-A (3) (C)

SECTION 5: Dispensary Designation (Complete only if designating a Dispensary)	
Name of Dispensary:	
City:	Telephone No.: ( )
Name of Dispensary Representative:	
Name of Non Grow Caregiver, if any, who may pick up marijuana for me at the dispensary:	

SECTION 6: Expiration and Renewal of Designation

Expiration:

This designation form expires on (month/day/year) _____, or no later than 12 months after the signature date in Section 7, whichever comes first.

Renewal:

The patient is required to complete a new designation form in order to renew the designation of a caregiver or dispensary.

SECTION 7: Patient Rights and Responsibilities

- My physician has certified that I have a condition that entitles me to participate in the Maine Medical Use of Marijuana Program until _____, when my physician certification expires. I have provided you with either a copy of that certification or a copy of my Maine Medical Use of Marijuana Program identification card as proof that I am authorized to participate in the program. I have also provided you a copy of my Maine issued driver license or other Maine issued photo identification card as proof of my identity.
- If I am visiting from another state, I have provided you with a copy of the MMMP physician certification form completed by my physician in the state of _____ as evidence that I live in a state that authorizes marijuana for medical purposes and have a debilitating condition authorized under Maine law. I have also provided you with a copy of the driver license or other state issued photo identification card issued by that state as proof of my identify.

In the event needed, you are hereby authorized to share this caregiver designation form and any copies of documents that I am required to provide to you with a member of the law enforcement community in order to verify the services you are providing to me are authorized under Maine law.

I have the right to terminate this agreement at any time upon written notice to you. This caregiver designation form is my property, and any authorized activity conveyed to you through this designation form terminates upon my notice to you. You must either dispose of the excess marijuana in your possession on my behalf, or replace me with another qualified patient. By rue of the Department of Health and Human Services, you will have 10 days from the date of notice to return this form to me at the address above.

In the event I terminate this agreement and you do not return this designation form to me, I authorize the Maine Department of Health and Human Services to demand the return of this designation form or take other action to enforce the Rules Governing the Maine Medical Use of Marijuana Program, which includes terminating the caregiver number that they assigned to you and that you have listed on this designation form.

_____	_____	_____
Print name of patient/guardian	**Signature of patient/guardian**	**Date**
_____	_____	_____
Print name of caregiver	**Signature of caregiver**	**Date**
_____	_____	_____
Print name of dispensary representative	**Signature of dispensary representative**	**Date**